Provider Nomination Form for Consumer Choice Option

CIGNA HealthCare of Georgia, Inc. & Connecticut General Life Insurance Company

To be Completed by Patient

Patient's Name	Employee's ID Number (and Name, if different than patient)	Group Number, if applicable
Patient's Address (Street, City, State, Zip)	Patient's Date of Birth / /	
	Patient's Telephone Number ( )	Patient's Fax Number ( )
By signing below, the Patient verifies that they are enrolled in CIGNA HealthCare's Consumer Choice Option. The Patient further acknowledges that the nominated provider is not an in-network or participating provider with CIGNA HealthCare. This provider, therefore, has not been credentialed by CIGNA HealthCare and thus CIGNA HealthCare cannot make any representations as to the quality of care the Patient may receive. The Patient also understands that any and all physicians, hospitals and any others who are not in-network providers must be nominated by the Patient and accepted by the CIGNA HealthCare prior to any service being performed by the provider in order for the service to be eligible for coverage under the Consumer Choice Option.		
_____ Patient's Signature (or legal representative's if Patient is a minor or incapacitated)		_____ Date

To be Completed by Provider

Name of Nominated Provider	Name of Provider Group, if applicable	Provider's Georgia License Number	Provider Tax ID Number
Provider Address (Street, City, State, Zip)		Provider's Telephone Number ( )	Provider's Fax Number ( )
		Hospital(s) Where Provider Has Privileges	
By signing below, the provider acknowledges that they are located within the state of Georgia and fully licensed by the state of Georgia. Provider also attests that he/she is not a CIGNA HealthCare participating provider and has not been credentialed by the plan.			
_____ Provider's Signature			_____ Date

Nominated Provider: Please complete all of the above indicated information, sign and forward this form via mail or facsimile to: Consumer Choice Option, CIGNA HealthCare of Georgia, Inc., 3500 Piedmont Road, Suite 200, Atlanta, GA 30305, fax number (404) 443-8998. Failure to complete all of the required information will result in disapproval of nomination. Upon receipt of the Provider Nomination Form, CIGNA HealthCare will contact the Provider's office to discuss the CIGNA HealthCare's Quality Management criteria and payment terms.

TO BE COMPLETED BY PROVIDER AFTER DISCUSSING NOMINATION WITH CIGNA HEALTHCARE

Provider: BY SIGNING BELOW YOU ARE AGREEING TO ACCEPT CIGNA HEALTHCARE'S PAYMENT TERMS ACCORDING TO CIGNA HEALTHCARE'S REIMBURSEMENT POLICIES. YOU ARE ALSO AGREEING TO COMPLY WITH CIGNA HEALTHCARE'S QUALITY MANAGEMENT CRITERIA. The criteria will include, but are not limited to: (i) pre-certification or prior approval of services; (ii) Patient eligibility at the time services are rendered; (iii) the services rendered qualifying as covered services under the Patient's benefit plan; and (iv) any cost sharing provisions in the Patient's benefit plan. This form is not to be construed as a guarantee of payment. Provider hereby agrees to accept CIGNA HealthCare's payment terms and agrees not to balance bill the Patient. Provider additionally agrees to comply with CIGNA HealthCare's rules and provisions.

_____ _____

Provider's Signature Verifying Acceptance of These Terms Date

Please keep a copy of this completed form and mail/fax the original to CIGNA HealthCare at the address/fax above. A confirmation letter will be mailed or faxed to the Provider.